

## **837 Professional – Waiver claim form**

This document is a field –by –field instructional help sheet. The fields are listed in a right to left format as they appear in the Provider Electronic Software. Examples of the values needed in order to process the claim are given. Those fields with “ Not Required” listed as a value, are present on the claim per HIPAA regulations and are not needed in order to process the claim. This software will **not** allow you to save a claim with a required field missing, however this does not guarantee that your claim will pay, just that the basic information is present. Auto populated fields have the valid value already present and do not need to be entered. \*\* Represents a list that must be created in order to process the claim. Please see attachment for directions on how to create the lists.

### **Header 1**

<b>FIELD</b>	<b>VALUE</b>
Claim Frequency	Is defaulted to 1 = new claim
Provider ID **	Your 7 digit billing provider number (Hint: this is the # on the top left corner of your Remittance Advice)
Taxonomy Code	Not Required
Last/Org Name	Will be auto populated when the provider number is selected from the provider list and then you hit the tab button on your keyboard
First Name	Will be auto populated when the provider number is selected from the provider list and then you hit the tab button on your keyboard
Client ID **	This is the MID (commonly the Social Security number) of the client you are billing services for
Account Number	Will be auto populated when the client number is selected from the client list and then you hit the tab button on your keyboard
Last Name	Will be auto populated when the client number is selected from the client list and then you hit the tab button on your keyboard
First Name	Will be auto populated when the client number is selected from the client list and then you hit the tab button on your keyboard
MI	Not Required
Medical Record #	Not Required
Signature on File	Auto – Populated to Y = Yes
Benefits Assignment	Auto – Populated to Y = Yes
Release of Medical Data	Auto – Populated to Y = Yes
Patient Signature	Must be appropriate to case ; commonly B = signature is on file
Report Type Code	Not Required
Report Transmission Code	Not Required

## **HEADER 2**

<b>FIELDS</b>	<b>VALUE</b>
Diagnosis Code	Are the conditions for which you are treating the client i.e. 642 = Hypertension. These can be acquired from the clients Primary Care Physician or your medical records.
Accident Related Causes	Not Required unless treatment is a result of an accident. If that is the case choose the most appropriate value from the drop down lists
Place of Service	Not Required on Header 2
Other Insurance Ind.	Is auto populated to N = no This may be changed to Y = yes if billing Medical Assistance as a secondary * please see attachment for further instructions when billing secondary claims
Special Program Code	Not Required
EPSDT Referral	Not Required fields

## **SRV 1**

<b>FIELDS</b>	<b>VALUE</b>
From DOS	The date you treated the client
To DOS	The date you stopped treating the client for this billing
Place of Service	Choose an appropriate value from the drop down list
Procedure	Is the service you are billing for
Modifiers	If applicable
EPSDT Ind.	Auto populated to N = No
Billed Amount	Will auto populate when claim is completed
Units	The total units you are billing for
Diag. Ptr.	This is related Diagnosis associated with this procedure. Example if you have three diagnoses for this client and the procedure you are billing for relates to the second condition the Ptr. Will be 2. Refer to header 2
Basic Unit of Measure	Auto populated to UN = Units
Unit Rate	Is the dollar amount you are billing for the services you rendered

## **SRV 2**

Nothing on this section is required for claims processing.